SAN ANTONIO BEHAVIORAL
HEALTHCARE HOSPITAL

Patient Demographic Information

Name: Click or tap here to enter text.

Sex (Check one): ☐ **Male** ☐ **Female**

Age: Click or tap here to enter text.

Social Security Number: Click or tap here to enter text.

Street Address: Click or tap here to enter text.

City Click or tap here to enter text. **State** Click or tap here to enter text.
Zip-Code Click or tap here to enter text.

Date of Birth: Click or tap to enter a date.

Marital Status: (Check one) ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widowed** ☐ **Separated** ☐ **Partner**

Race: (Check one) ☐ **White** ☐ **Black** ☐**Asian** ☐ **Amer. Indian** ☐ **Hispanic** ☐ **Pac. Islander** ☐ **Other:** ____________

Home Phone: Click or tap here to enter text.

Cell Phone: Click or tap here to enter text.

Employer or School: Click or tap here to enter text.

Email Address: Click or tap here to enter text.

Preferred Pharmacy Location and Phone Number: Click or tap here to enter text.

Who referred you to San Antonio Behavioral Healthcare Hospital? Click or tap here to enter text.

Have you been a patient at San Antonio Behavioral Healthcare Hospital before? Click or tap here to enter text.

Emergency Contact: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

Primary Insurance Company Name: Click or tap here to enter text.	**Policy Number:** Click or tap here to enter text.	**Secondary Insurance Company Name:** Click or tap here to enter text.	**Policy Number:** Click or tap here to enter text.
Policy Holder's Name/Relationship: Click or tap here to enter text.	**Policy Holder's Social Security #:** Click or tap here to enter text.	**Policy Holder's Name/Relationship:** Click or tap here to enter text.	**Policy Holder's Social Security #:** Click or tap here to enter text.
Policy Holder's Employer: Click or tap here to enter text.	**Policy Holder's DOB:** Click or tap to enter a date.	**Policy Holder's Employer:** Click or tap here to enter text.	**Policy Holder's DOB:** Click or tap to enter a date.

Briefly describe the symptoms you are experiencing at this time and why you are wanting IOP/PHP services: Click or tap here to enter text.

Primary Care Physician: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

Psychiatrist: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

Therapist/Counselor: Click or tap here to enter text.

Phone Number: Click or tap here to enter text.

By signing below, I authorize staff at San Antonio Behavioral Healthcare Hospital to verify my insurance benefits and to assist with referrals:

Patient/Guardian Signature: Click or tap here to enter text.

Date: Click or tap to enter a date.

Email this form to sabhh.outpatient@sanantoniobehavioral.com or fax to 210-541-5279. Any questions please call us at 210-541-5289.

Patient Concerns

Self-harm	YES	NO	If yes, explain:
CURRENT THOUGHTS OR ACTS TO SELF-HARM *(cutting, burning, hitting)*	☐	☐	Click or tap here to enter text.
SUICIDAL IDEATION	☐	☐	Click or tap here to enter text.
SUICIDAL INTENT *(within last 7 days)*	☐	☐	Click or tap here to enter text.
HAVE YOU HAD A RECENT SUICIDE ATTEMPT? *(within last 6 months)*	☐	☐	Click or tap here to enter text.
DO YOU HAVE A HISTORY OF SUCIDIALITY?	☐	☐	Click or tap here to enter text.
Harm to others			
CURRENT/PAST THOUGHTS OR ACTIONS TO HARM SOMEONE ELSE	☐	☐	Click or tap here to enter text.
Family History			
FAMILY HISTORY OF SUICIDE / MENTAL HEALTH / SUBSTANCE ABUSE	☐	☐	Click or tap here to enter text.

Psychosis			
DO YOU HAVE OR HAVE YOU EVER EXPERIENCED PSYCHOSIS	☐	☐	Click or tap here to enter text.

Substance Abuse
Please check if you have used any of the following
☐ Alcohol ☐MARIJUANA ☐ STIMULANTS ☐ OPIATS ☐ COCAINE ☐ OTCs ☐ TOBACCO ☐ HALLUCINIGENS ☐ METHADONE ☐RX PAIN MEDS ☐ HERION ☐TRANQUILIZER ☐METHAMPHETAMINE ☐ INHALANTS ☐SEDATIVES ☐ BENZODIAZEPINES ☐OTHER: Click or tap here to enter text.

SUBSTANCE (LAST 30 DAYS ONLY)	AGE OF 1ST USE	CURRENT AMOUNT	CURRENT FREQUENCY	CURRENT DURATION	DATE OF LAT USE/AMOUNT	ROUTE OF USAGE (I.V., SMOKE, ETC.)
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

LIFE AREAS			
	YES	NO	If yes, explain:
PROBLEMS AT WORK OR SCHOOL	☐	☐	Click or tap here to enter text.
ANY DEVELOPMENTAL DISABILITIES?	☐	☐	Click or tap here to enter text.
RELATIONSHIP ISSUES	☐	☐	Click or tap here to enter text.
LEGAL ISSUES (Probation, Parole, DUI, etc.) P.O./PROBATION OFFICER: Click or tap here to enter text. ROI SIGNED: ☐ YES ☐ NO	☐	☐	Click or tap here to enter text.

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FINANCIAL ISSUES PATIENT RECIVES DISABILITY:	☐	☐	Click or tap here to enter text.
WHO DOES PATIENT LIVE WITH?Click or tap here to enter text.	SUPPORT SYSTEM:Click or tap here to enter text.		ROI SIGN: ☐ YES ☐ NO *If yes, for whom:* Click or tap here to enter text.

Physical			
SLEEP DISTURBANCE	☐ NONE ☐ HYPERSOMNIA	☐ FREQUENT AWAKENING ☐ DIFFICULTY FALLING ASLEEP	☐ EARLY MORNING AWAKENING ☐ NIGHTMARES ☐ OTHER:Click or tap here to enter text.
HOURS OF SLEEP-IN 24-HOUR PERIOD Click or tap here to enter text.	Current #Hours Sleep: Click or tap here to enter text. Current Consecutive # Hours of Sleep: Click or tap here to enter text. Comments: Click or tap here to enter text.		
APPETITE	☐ No Change in Appetite ☐ Decrease in Appetite ☐ Increase in Appetite		
	Increase / Decrease Weight #:Click or tap here to enter text. Over What Time Period: Click or tap here to enter text.		
	Any eating issues: ☐YES ☐ NO *If Yes, describe:*Click or tap here to enter text.		

ADDITIONAL INFORMATION
Briefly describe any other issues you fell we need to know:
Click or tap here to enter text.